

Please fax both pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form Sickle Cell Disease (SCD)

accredo[®]
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information



Please attach copies of front and back of the patient's medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify _____

Insurance company _____ Phone _____

Insured's name _____ Insured's employer _____

Relationship to patient _____ Identification # _____ Policy/group # _____

Prescription card: Yes No If yes, carrier _____ Policy # _____ Group # _____

Patient eligible for Medicare? Yes No Does patient have a secondary insurance? Yes No

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

3 Clinical Information

Sickle Cell Diagnosis: D57 (sickle cell disorders) D57.0 (Hb-SS disease with crisis) D57.1 (SCD without crisis)
D57.2 (Sickle-cell/Hb-C disease) D57.00 (Hb-SS disease with crisis, unspecified)
D57.40 (Sickle-cell thalassemia without crisis) D57.20 (Sickle-cell/Hb-C disease without crisis)
D57.219 (Sickle-cell/Hb-C disease with crisis, unspecified) Other

Height _____ cm/in Weight _____ kg/lbs Date taken _____

NKDA Known drug allergies _____

Concurrent meds _____

Additional clinical information _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/ Formulation	Directions	Quantity/Refills																				
Endari®	5 Gram (GM) Packet	<table border="1"> <thead> <tr> <th>Weight in kilograms</th> <th>Per dose in grams</th> <th>Per day in grams</th> <th>Packets per dose</th> <th>Packets per day</th> </tr> </thead> <tbody> <tr> <td>less than 30</td> <td>5</td> <td>10</td> <td>1</td> <td>2</td> </tr> <tr> <td>30 to 65</td> <td>10</td> <td>20</td> <td>2</td> <td>4</td> </tr> <tr> <td>greater than 65</td> <td>15</td> <td>30</td> <td>3</td> <td>6</td> </tr> </tbody> </table> <p>Mix 1 packet (5 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily. Mix 2 packet(s) (10 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily. Mix 3 packet(s) (15 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4-6 ounces of food and take by mouth 2 times daily.</p> <p>Other _____</p>	Weight in kilograms	Per dose in grams	Per day in grams	Packets per dose	Packets per day	less than 30	5	10	1	2	30 to 65	10	20	2	4	greater than 65	15	30	3	6	Dispense: 1-month supply 3-month supply Other _____ _____ Number refills authorized _____ _____
Weight in kilograms	Per dose in grams	Per day in grams	Packets per dose	Packets per day																			
less than 30	5	10	1	2																			
30 to 65	10	20	2	4																			
greater than 65	15	30	3	6																			
Oxbryta®	500mg Tablets for oral use	Take 3 tablets (1500mg) by mouth once daily Other _____	Dispense: 1-month supply 3-month supply Other _____ _____ Number refills authorized _____ _____																				
Oxbryta®	300mg Tablets for oral suspension	<table border="1"> <thead> <tr> <th>Weight in kilograms</th> <th>Recommended dose (once daily)</th> </tr> </thead> <tbody> <tr> <td>40kg or greater</td> <td>1,500mg</td> </tr> <tr> <td>20kg to less than 40kg</td> <td>900mg</td> </tr> <tr> <td>10kg to less than 20kg</td> <td>600mg</td> </tr> </tbody> </table> <p>Take 5 tablets (1500mg) dispersed for oral suspension in 25mL of clear drink daily. Take 3 tablets (900mg) dispersed for oral suspension in 15mL of clear drink daily. Take 2 tablets (600mg) dispersed for oral suspension in 10mL of clear drink daily.</p> <p>Other _____</p> <p>Dispense tablets for oral suspension immediately before administration in a cup and in room temperature clear liquid (such as drinking water or clear soda) before swallowing. Minimum recommended volume of clear drink is 5mL (1 teaspoon) per tablet for oral suspension.</p>	Weight in kilograms	Recommended dose (once daily)	40kg or greater	1,500mg	20kg to less than 40kg	900mg	10kg to less than 20kg	600mg	Dispense: 1-month supply 3-month supply Other _____ _____ Number refills authorized _____ _____												
Weight in kilograms	Recommended dose (once daily)																						
40kg or greater	1,500mg																						
20kg to less than 40kg	900mg																						
10kg to less than 20kg	600mg																						

Prescriber's signature required (sign below) (Prescriber attests this is his/her legal signature. NO STAMPS)

**SIGN
HERE**

Date

Dispense as written

Date

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.